aahpm®
QUARTERLY

WINTER 2024

HOW CAN WE KEEP HOME-VISITING HOSPICE AND PALLIATIVE STAFF
SAFE?

PAGE 11

aahpm®
AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

2024-2025 BOARD OF DIRECTORS

OFFICERS

Vicki Jackson, MD MPH FAAHPM	*President*
Holly Yang, MD HMDC FACP FAAHPM	*Immediate Past President*
Arif Kamal, MD MBA MHS FASCO FAAHPM	*President-Elect*
Elise C. Carey, MD FACP FAAHPM	*Treasurer*
Kimberly Curseen, MD FAAHPM	*Secretary*

DIRECTORS AT LARGE
Michael Barnett, MD MS FAAP FAAHPM
Rachelle Bernacki, MD MS FAAHPM
Gary Buckholz, MD HMDC FAAHPM
Sandra Gomez, MD FAAHPM
Christopher A. Jones, MD MBA HMDC FAAHPM
Dio Kavalieratos, PhD FAAHPM
Stacie Levine, MD FAAHPM
Mary Lynn McPherson, PharmD PhD BCPS FAAHPM
Laura J. Morrison, MD FACP FAAHPM
Lindsay Ragsdale, MD FAAP FAAHPM
Alvin L. Reaves, III, MD FACP FAAHPM
Phillip Rodgers, MD FAAHPM
Bethany Cox Snider, MD HMDC FAAHPM
Alison Wiesenthal, MD FACP FAAHPM

QUARTERLY EDITORIAL BOARD

EDITOR IN CHIEF
Cory Ingram, MD MS FAAHPM

ASSOCIATE EDITOR
Eric R. Goodlev, MD

EDITORIAL BOARD
Kyle Edmonds, MD FAAHPM
Kristin Forner, MD FAAHPM
Jon P. Furuno, PhD
David Harris, MD
Jane E. Loitman, MD MBA MS FAAHPM
Katie Mechler, MD
Leah Rosenberg, MD

STAFF

Steve Smith, MS CAE FAAMSE	*Interim Chief Executive Officer*
Katherine Ast, MSW LCSW	*Director, Quality and Research*
Kelly Becker	*Data Entry Specialist*
Patrick Belics	*Director, Development*
Yumeka Brown, CAE	*Senior Director, Governance and Operations*
Julie Bruno, MSW LCSW	*Chief Learning Officer*
Wendy Chill	*Director, Health Policy and Government Relations*
Leah Farfan	*Coordinator, Education and Learning*
Nancy Garcia	*Coordinator, Governance and Operations*
Charli Holstein	*Coordinator, Membership*
Katie James, MA	*Managing Editor*
Melissa Koch	*Manager, Strategic Events Management*
Natalia Kot	*Coordinator, Registration*
Jerrod Liveoak	*Senior Managing Editor*
Mickey Martin	*Senior Manager, Sales*
Kelly McKenna, MA	*Manager, Analytics*
Phyllis Milz	*Senior Manager, Accounting and Financial Management*
Annmarie Morrison	*Member Services Representative*
Emily Muse, CAE	*Senior Director, Marketing and Membership*
Theresa Nissen	*Coordinator, Education and Learning*
Elizabeth Smith	*Manager, Marketing and Communications*
Melissa Stachorek	*Coordinator, Marketing and Digital Communications*
Linda Sterling	*Manager, DEI and Membership Engagement*
Julie Tanner, BSN RN-BC CHPN	*Director, Education and Learning*
Laura Witt, MS-HSM	*Manager, Workforce Initiatives*

VOLUME 25 | ISSUE 4

TABLE OF CONTENTS

Send address changes, administrative correspondence, or letters to the editor to AAHPM by mail to 1061 American Lane, Suite 310, Schaumburg, IL 60173-4973; phone 847.375.4712; fax 847.375.6475; or email info@aahpm.org. *AAHPM Quarterly* is published by the American Academy of Hospice and Palliative Medicine (AAHPM). ©2024 by AAHPM. Advertising is accepted. Contact Mickey Martin at mmartin@connect2amc.com.

The information presented and opinions expressed herein are those of the authors and do not necessarily represent the views of the American Academy of Hospice and Palliative Medicine. Any clinical or technical recommendations made by the authors must be weighed against the healthcare provider's own judgment and the accepted guidelines published on the subject.

A MESSAGE FROM THE PRESIDENT

REFLECTIONS ON LEADERSHIP AND COMMUNITY: A YEAR OF GROWTH AND GRATITUDE

As my term as president of the American Academy of Hospice and Palliative Medicine (AAHPM) comes to a close, I find myself reflecting on this past year with immense gratitude. Serving in this role has been a true honor, a challenge at times, and a profound learning experience. I am definitely better because of it. I have witnessed the unwavering dedication of our members and staff, the resilience of our field, and the power of collective action. In this final column, I want to share several pieces of learning I will take away from my time as president—lessons that I hope will inspire others to engage, advocate, and lead in ways that strengthen our shared mission.

The Power of Community

The greatest strength of AAHPM lies in its people. From seasoned experts to those just beginning their careers, our members bring a deep well of knowledge, compassion, and commitment. Time and again, I have seen the power of our community to support one another—through mentorship, shared learning, and advocacy. Whether through special interest groups (SIGs), committees, or informal connections, engaging with our community enriches both our profession and our own professional growth. If you have not yet found your niche within AAHPM, I encourage you to reach out, connect, and find ways to contribute. We are delighted to help you find ways to make an impact and find your home in this wonderful organization. The Annual Assembly is a great place to start!

Leadership Is Advocacy

Being a leader means being an advocate—not only for our field but for the patients and families we serve and for each other. This last year has reinforced the importance of speaking up for policies that advance access to palliative and hospice care, improve clinician well-being, promote innovation and science, and ensure health equity. Our collective voices carry weight, and when we advocate together—whether at the national level through our work with the American Medical Association or within our own institutions—we can create meaningful change. I urge each of you to find ways to advocate, whether by engaging in policy discussions, participating in AAHPM's advocacy efforts, or sharing the impact of our work with others.

We Need the Voice of Every Member

A key priority for me this year was finding ways to be in dialogue with members—regardless of discipline, background, or career stage—and it is clear that all members are critical contributors to AAHPM. We are a broad and inclusive organization, and that range of perspectives is one of our greatest assets. Whether through listening sessions, direct outreach, or expanding opportunities for engagement, I have learned that leadership is about creating space for meaningful dialogue. We need all perspectives to make our organization as strong as it can possibly be. Your insights, experiences, and ideas help shape the future of AAHPM and our field.

Small Actions Create Big Impact

Leadership is often perceived as grand gestures, but in reality it is the accumulation of small, thoughtful, consistent actions that create lasting impact. I have been inspired by the members who volunteer their time—those who mentor students, contribute to guideline development, or simply check in on colleagues. These seemingly small acts build the fabric of our community. If you are looking for ways to get involved, consider joining a committee, participating in a SIG, or nominating a colleague for recognition. Every contribution matters.

The Future of Our Field Depends on Engagement

As we navigate challenges such as workforce shortages, policy shifts, and the ongoing evolution of health care, our field needs engaged and passionate leaders more than ever. AAHPM offers countless ways to get involved, from leadership opportunities to research initiatives to education and networking events. If you have ever considered stepping forward in a new way—do it. The future of hospice and palliative medicine is being shaped by those who show up, share their voices, and work together for progress.

I pass the torch to the next president, Dr. Arif Kamal, with deep appreciation for this community and the work we do. Thank you for your trust, your dedication, and your commitment to ensuring that patients and families receive the high-quality compassionate care that they deserve. It has been an honor to serve, and I look forward to continuing this journey alongside you all. ●

With gratitude,

Vicki Jackson, MD
AAHPM President

CLINICAL PEARLS

COUNTERTRANSFERENCE IN PALLIATIVE CARE

Gregg A. Robbins-Welty, MD MS HEC-C

"That didn't go well," I muttered. Deflated, and perhaps indulging in self-pity, I thought I'd done everything right. Yet, I hadn't connected with the patient the way I wanted. *Why do I feel this way? What could I do differently next time?* These and other similar questions open the door to understanding the use of psychotherapeutic techniques in palliative care.

Most palliative care specialists (PCS) don't see themselves as psychotherapists. Images of a Freudian leather chaise lounge and elbow-patched tweed feel worlds away from an intensive care unit or oncology ward. Few PCS have advanced, or even basic, training in psychotherapy. And while there is a growing number of psychiatry-trained PCS, most come from a more traditional, white-coated background.[1] Nevertheless, skilled PCS routinely use psychological techniques to forge meaningful connections with seriously ill patients and their families.

Palliative care specialists are trained to be highly observant, attuned to noticing and responding to emotional subtleties. One classic example is avoiding the trap of answering a patient's emotional plea disguised as a question. I was taught as a medical student, "If you respond to 'How could cancer have happened to me?' with a discussion about oncogenes, you've missed the boat entirely." I'm still terrified to discuss oncogenes with patients—but the point is clear: PCS have the instincts to use psychotherapeutic techniques to better understand their patients, ultimately improving outcomes.

One key psychotherapeutic concept that directly applies to palliative care is countertransference. While transference refers to the patient's feelings projected onto the clinician, countertransference is the clinician's emotional response to the patient.[2] In essence, grasping countertransference requires PCS to use their inherent observational and emotional skills to reflect inwardly.

Countertransference is not only shaped by the clinician's current relationship with the patient but also influenced by every other relationship they've had—extending far beyond the bedside. When two people first meet, there is an immediate rush of initial impressions, many of which are based on intuition and prior experience.[3,4] In a clinical space, additional expectations and role responsibilities come into play. Even before the encounter, emotions are likely to surface; mental scaffolding is established, and emotional triggers are set. Influenced by background, early parental relationships, spiritual beliefs, and prior familiarities with grief, PCS enter each encounter with much more than just their clinical expertise.

Countertransference extends beyond our conscious awareness as well. Unspoken feelings may reveal themselves in our actions—perhaps by cutting visits short, avoiding patients with difficult families, or focusing on symptoms alone.[4,5] For patients we feel positively toward, we may unintentionally and optimistically overestimate their prognosis. Diving deeply into a patient's story can uncover our own vulnerabilities. Emotional resonance or dissonance with our own life experiences can complicate our ability to address feelings of sadness, helplessness, or frustration.[4] Acknowledging these emotions is crucial, as neglecting them may lead to unproductive disconnection. By recognizing our countertransference, we can transform annoyance or confusion into empathy.

Self-reflection presents its own set of challenges. It requires time and emotional effort, or maybe it was discouraged during training. While completely natural, it can feel uncomfortable not to form an immediate bond with every patient or to find certain interactions less rewarding. Recognizing these feelings—both positive and negative—can enhance our emotional management, improve patient interactions, and in some cases even have diagnostic value. For example, patients with borderline personality disorder often trigger strong emotions in clinicians. Recognizing this countertransference can aid in diagnosis.

So, how can PCS better understand their countertransference and utilize it to enhance patient outcomes? **Table 1** offers some suggestions. Traditional guidance often recommends seeking personal therapy.[6] Additional strategies might include consulting with colleagues with psychological expertise about challenging cases, or practicing mindfulness. Mindfulness helps us identify our emotions in real-time—like feeling sadness when a patient reminds us of a loved one. Furthermore, leaning on our interdisciplinary team—social workers, psychologists, and chaplains—can provide valuable support and insights into the complex emotions that arise in end-of-life care.[2]

The common experience of a visit that "did not go well" is something all PCS can relate to. *What could I do differently next time?* Introspection is essential. ●

References:

1. Shalev D, Brenner K, Carlson RL, et al. Palliative care psychiatry: building synergy across the spectrum. *Curr Psychiatry Rep.* 2024;26(30):60-72. doi:10.1007/s11920-024-01485-5.
2. Katz RS, Johnson TA, eds. *When Professionals Weep: Emotional and Countertransference Responses in Palliative and End-of-Life Care.* New York, NY: Routledge; 2016.
3. Boston PH, Mount BM: The caregiver's perspective on existential and spiritual distress in palliative care. *J Pain Symptom Manage.* 2006;32(1):13-26.
4. Rosenberg LB, Brenner KO, Jackson VA, et al. The meaning of together: exploring transference and countertransference in palliative care settings. *J Palliat Med.* 2021;24(11):1598-1602.
5. Wilson SN: The meanings of medicating: pills and play. *Am J Psychother.* 2005;59(1):19-29.
6. Riordan P, Briscoe J, Kamal AH, Jones CA, Webb JA. Top ten tips palliative care clinicians should know about mental health and serious illness. *J Palliat Med.* 2018;21(8):1171-1176.

Gregg Robbins-Welty, MD MS HEC-C is an internist, psychiatrist, ethicist, and palliative medicine fellow at the University of Pittsburgh. He serves as the chair of the AAHPM early career special interest group.

Table 1: Managing Countertransference for Palliative Care Specialists: Before, During, and After the Encounter

Emotional Pulse Check

Ask yourself, "Am I feeling tired, rushed, anxious, worried, dread, or something else?"

Ask yourself, "Is this case too close to home (eg, a patient with similar disease as a family member)?"

Notice attention and if it wanders.

Notice feelings as they arise (eg, I felt disappointed or angry that the patient disagreed with my recommendation).

Consider the impact of clinician attitudes and behaviors on the patient's behaviors.

Reflection

Are mindfulness techniques (eg, taking deep breaths, focusing attention on the patient while acknowledging competing demands on time and emotional energy) necessary?

Gently redirect attention back to patient.

Observe instances where attention is being given to tasks, exercises, and summaries instead of to the patient.

Reflect on feelings before, during, and after.

Support

Debrief with the team.

Consider individual psychotherapy.

Set time aside for self-reflection.

Practice mindfulness to remain self-aware.

ART OF CARING

PUMPKIN PIE IN JULY

Katharine L. Modisett, MD

Parents have mantras. “Wash your hands.” “Make eye contact when you’re talking.” “Remember the Golden Rule.” When our 4-year-old daughter was diagnosed with acute lymphoblastic leukemia, I found myself repeating a new one: “We have choices with some things and not with others.” Childhood leukemia is not a choice anyone would make. It seemed especially unbelievable to be handed this diagnosis after I had spent the previous 11 months staring down death and injustice daily as an intensivist during the COVID-19 pandemic. Vaccines were just becoming available when our daughter was diagnosed and the sense of relief that the rest of the world felt was lost on me. I remember coming home and opening the door to our house for the first time after learning Evelyn had leukemia and just declaring to my in-laws, “What the $^&*!??”

The first night I was in the hospital with her, we were admitted through the emergency department with a hemoglobin of 3.9 and no diagnosis. My husband and our 15 month old were home when we called on FaceTime to tell them we were staying. I was trying to mime through the tears how serious the situation was to my non-medically trained husband while my daughter was clarifying which of her Barbies she needed him to bring the next day. On the pediatric medical floor, I watched her like a hawk, and when she spiked a fever of 102, she was ordered Tylenol. She refused and refused and no amount of cajoling or bribing or explaining or waiting was working. I felt terrible as I squeezed the plunger in between her clenched teeth and even worse when we debriefed afterwards. She likened me to “the evil stepmother from Cinderella.” That was the last time I had to force her to take medication. It was the last time I turned into a version of myself I hated.

We didn’t have a choice about leukemia. I did have a choice about how I was going to parent through this hell. I became a fierce advocate for her. I knew I was part of a system that made mistakes and often times didn’t keep a patient as its center focus. I was not ready to relinquish complete trust in her care team. I felt one of the most dangerous places for our daughter to be was in the hospital or clinic, and therefore I resolved to stay by her side. For the next 2.5 years, she had only a single blood draw for which I could not be there. And yes, I was that parent asking the nurse to wait another few seconds for the alcohol to dry before connecting the tubing to her MediPort. I also wanted to empower our girl—I didn’t want her to become a disemboweled vessel for chemotherapy. She needed to make her own decisions and choices when she could. She needed to have some autonomy over this little body that had decided to let its genetics go off the rails, wreaking havoc inside and out.

One thing we could control was how to take medications at home. These twice daily medications were in addition to all the infusions, transfusions, and lumbar punctures she endured. Our pediatric oncologist cautioned us against neglecting this part of our treatment plan, citing statistics about noncompliance and recurrence of disease. This responsibility did not land lightly on my husband and myself. When it came to helping our daughter take her medications, nothing was off the table for getting this done to help secure her odds at a good prognosis.

Even though we were determined, it was not easy. When we were discharged home, we found the process of getting our daughter to take her medications like a freight delivery—the last mile was the clinch point. We had the prescription, the insurance authorization, a pill box (she compared hers to her Grandpa’s), a pill splitter, and a monthly schedule printed by our team. We tried putting meds in applesauce (too yucky), in cake frosting (too sweet), and just with sips of water (too hard to swallow). The frightened and rationalizing part of me then found myself on PubMed looking at studies from decades ago showing the high binding affinity of chemotherapy medications and dairy products. Why hadn’t our team told us this? What else weren’t they telling us? Did we just increase our daughter’s chance at recurrence with that week of yogurt-laced meds?

I don’t remember how the idea of pumpkin pie as a substrate came into the picture, but it stuck. Our gloved hands easily squished the pill fragments into the center filling of the dessert. Our daughter was able to swallow several bites with whatever mercaptopurine, methotrexate, famotidine, amlodipine, dexamethasone, or trimethoprim-sulfamethoxazole she was slated to take that day. For months, we lived pumpkin pie to pumpkin pie. We had the brand name boxed versions stacked in our freezer. We went grocery store to grocery store to find any baked fresh. My mother offered to travel 500 miles to make a homemade version. During the summer months, I asked bakery managers about their stock and was told they were only baked seasonally, "although, the older folks would love them year-round." If they only knew! As long as we had a pumpkin pie in our possession, and at least one or two as back-ups, we had some sense of control.

The pies went with us wherever we went. If it was a day trip, we would scoop out the filling and put it in a plastic container inside her little red lunchbox that held a disposable spoon and all her medications. Our longer trips during those years were never more than an hour away from a children's hospital, and we always had at least one whole pie. We became accustomed to living our lives on a short leash bookended by our phone alarms going off twice daily and our younger daughter's punctuated shouting, "Meds!" We sought to give our kids as normal a childhood as possible with leukemia in the background. Ironically, our daughter never was worried about the pumpkin pie—she took her meds twice a day without a fuss. She never asked if we had a pumpkin pie or not, and we tried to shield her from all the behind-the-scenes acrobatics to make sure we always had one…even in July. The fact that she wasn't anxious about the procurement of pies felt like a success.

While we were rarely asked about compliance at our clinic appointments, I yearned to tell my physician colleagues what I had discovered that they hadn't taught us in medical school: this part is way harder than calculating a dose and sending an e-script. No one tells you how hard it is, but we are doing it. We are doing it! Could our attending physician empathize with us? She had her own children too. Did she ever imagine herself in my shoes? Did she think this was easy to do? Or that we were lucky because we were standard risk? By not asking me about anything more than symptoms and side effects, I felt the distance between myself and the attending widen.

It's now been a year since my daughter has had any chemotherapy. She has no signs of recurrence, her hair has grown back, and she is soaking in the pure joy of being a kid. When her treatment finished, we decided to move across the country for a fresh start. In that frenzied time as the packers descended on our home, the stockpiled frozen pies were discarded in the compost. However, two cans of pumpkin pie filling followed us and sit in the pantry of our new home. I imagine I'll be able to throw them out once they reach their expiration dates. While I will always be grateful for those pies, I will never look at that Thanksgiving dessert in the same way. My hope is that my daughter will have many, many holidays where she only associates pumpkin pie as deliciousness shared with loved ones. I will feel success if I need to remind her of what they once meant for our family. ●

Dr. Modisett is a practicing critical care physician in Denver, CO. She can be reached at katharine.modisett@gmail.com.

Want to see your creative writing, photography, art, or illustration in *AAHPM Quarterly*? Submit your work to info@aahpm.org today.

ADVOCACY UPDATE

CONGRESS ACTS ON TELEHEALTH FLEXIBILITIES: AAHPM WILL CONTINUE ADVOCACY EFFORTS

Wendy Chill

The issue of telehealth has been very prevalent since federal flexibilities put in place related to the COVID-19 public health emergency (PHE) allowed for extended use of these services. With the PHE having ended in May 2023, many of the federal rules allowing for these various flexibilities have come to an end. While access to telehealth has remained, these flexibilities were set to expire at the end of 2024. AAHPM has been steadily advocating for extensions of these provisions to allow its members to continue to provide valuable services to individuals with serious illness.

There are multiple telehealth-related policy issues of interest to Academy members: use of telehealth to prescribe controlled substances; use of telehealth for the face-to-face (F2F) visit for recertification of the Medicare hospice benefit; and extending current telehealth flexibilities within the Medicare program, such as geographic and originating site restrictions.

Over the past year, AAHPM advocated for these flexibilities to continue beyond 2024. These provisions have been addressed at the federal level, but there will be more work to do in 2025.

Use of Telehealth to Prescribe Controlled Substances

For years, the Drug Enforcement Administration (DEA) had implemented rules that allowed flexibilities for physicians to prescribe controlled substances using telehealth. Media reports had indicated that the DEA may have been set to end these flexibilities, creating access issues for patients in hospice and with serious illness.

AAHPM strongly advocated for these flexibilities to be maintained. In August 2024, the Academy participated in a meeting with the Office of Management and Budget to discuss the original proposed rule from 2023, regarding the use of telehealth to prescribed controlled substances, reiterating its position that the DEA account for the unique needs of seriously ill patients—including those near the end of life—when finalizing policies related to the prescribing of controlled substances via telemedicine. The Academy had previously submitted comments on this proposed rule, and Joe Rotella, MD, provided testimony to the DEA.

AAHPM also signed onto a letter requesting the DEA issue a new proposed rule on the matter as well as letters to Congressional leadership urging legislative action to extend prescribing flexibilities for 2 years and to urge the DEA to promulgate permanent rules creating a special registry for certain practitioners to prescribe controlled substances via telehealth. The Academy also worked in coalition with the Alliance for Connected Care on this issue.

Where Does This Issue Currently Stand?

In November 2024, the DEA and the Department of Health and Human Services (HHS) released a temporary rule, *Third Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications*, which extends the telemedicine flexibilities that have been in place since March 2020 for prescribing controlled medications via the practice of telemedicine until **December 31, 2025**. You can see the notice from the DEA here.

Subsequently, in January 2025, the DEA and HHS released a proposed rule to create a special registration process for the purpose of prescribing controlled substances via telehealth. This rule includes a specific provision that would create an Advanced Telemedicine Prescribing Registration for "certain specialized physicians and board-certified mid-level practitioners," which would allow the prescribing of controlled substances without an in-person visit. This special registration type would include hospice and palliative care physicians, as well as mid-level practitioners who are board-certified in hospice and palliative care.

AAHPM is excited that the drafting of this proposed rule has taken the Academy's advocacy efforts around the needs of patients with serious illness into account. The Academy is currently reviewing the full proposed rule and will be submitting comments to the DEA. It is important to note that **this rule is not yet final and is subject to change**. AAHPM will be sure to keep members informed on the status and content of this rule.

Use of Telehealth for the Face-to-Face Visit for Recertification of the Medicare Hospice Benefit

Under the current telehealth flexibilities, the F2F visit is permitted to be done via telehealth. This flexibility was set to expire at the end of 2024. AAHPM has supported the CONNECT for Health Act, which includes an extension for the F2F visit via telehealth. The Academy signed onto a letter to House and Senate leadership advocating for the extension of this flexibility, and subsequently worked with the National Alliance for Care at Home, LeadingAge, and the National Partnership for Healthcare and Hospice Innovation to directly reach out to Congressional leaders to reiterate the importance of this policy.

Where Does This Issue Currently Stand?

As part of the American Relief Act, 2025, the end-of-year funding package that was signed by President Biden, the flexibility allowing the F2F visit to be done virtually was extended until **March 31, 2025**. While this is good news in that it maintains the allowance for this service to be provided virtually, AAHPM and its partners will have work to do in 2025 to advocate for either a longer or a permanent extension of this flexibility.

Extending Other Telehealth Flexibilities Within the Medicare Program

The existing telehealth flexibilities within the Medicare program, such as the elimination of geographic and originating site restrictions, were also due to expire at the end of 2024. AAHPM supported the Telehealth Modernization Act, which would have extended such provisions. This bill initially passed unanimously out of the House Energy and Commerce Committee and had bipartisan support.

Where Does This Issue Currently Stand?

As with the F2F telehealth provision in the American Relief Act, 2025, these types of Medicare telehealth flexibilities were extended until **March 31, 2025**. Similarly, AAHPM will be working with its members over this next year to advocate for a longer or permanent extension of these flexibilities.

The Academy has advocated for the above telehealth-related policies throughout 2024 and will continue to do so moving forward to ensure the patient populations its members serve will keep their access to necessary services without interruption. AAHPM has been excited to see so many of its members actively taking part in these advocacy efforts through its Legislative Action Center. This will remain a priority for AAHPM, and members should be on the lookout for future opportunities to make their voices heard on these important policy issues. ●

Wendy Chill is AAHPM's director of health policy and government relations. For more information or questions about the Academy's advocacy efforts, email info@aahpm.org.

HOW CAN WE KEEP HOME-VISITING HOSPICE AND PALLIATIVE STAFF SAFE?

LARRY BERESFORD

Douglas Brant, age 56, an experienced home healthcare nurse with Providence VNA in Spokane, WA, was shot and killed by his patient's grandson during a home visit on December 1, 2022. It was his first visit to the patient's home, and the grandson was said to have a history of mental health issues and physical aggression.

Although this is one of only a few known instances of fatalities for home-visiting staff of home care, hospice, or palliative care teams, there have been many more cases of verbal or physical abuse, aggression, intimidation, or harassment. Data are spotty, but cases of gun threats, aggressive dogs, known psychiatric issues, criminal activity such as drug dealing, theft of property, dangerous or unhygienic conditions, heated conflicts between family members, and the like do happen. And we know that healthcare and social assistance workers overall are five times more likely to experience workplace violence than workers in other industries.[1]

This violence might be considered the other side of the coin from the dilemmas of the elder abuse silent epidemic described in the last *Quarterly* newsletter. It can greatly impact staff, causing burnout, depression, anxiety, post-traumatic stress disorder, and decisions to leave the field. But it can also make it harder for hospice teams to ensure equal access to care for all eligible patients if fears for personal safety limit the team's ability to respond to patients in unsafe neighborhoods or problematic living situations. How do agencies balance these competing demands?

Bethany Snider, MD HMDC FAAHPM, senior vice president and chief medical officer of Hosparus Health, a hospice and palliative care organization based in Louisville, KY, said her agency has experienced instances of threatened or actual violence. “Historically, in hospice care, we knew there was some inherent risk in this work, but it really wasn’t top of mind 15 years ago, 10 years ago even,” Dr. Snider said.

She recalled instances where she was accompanied on a home visit by a police escort, but that was rare. “I think over the past 4 years, this has become a much bigger challenge for our patients and our staff, where we’ve had to take proactive approaches to try to address concerns about safety and even violence in the workplace.”

PREPARE FOR THE WORST

“Some advice I give to colleagues at hospice and palliative care organizations is that you need to prepare for the worst,” Dr. Snider said. “You need good processes that you have developed and tested. What do staff do when they’re in a situation where they don’t feel safe? Who do they call? What do they say? And you need to practice those things, not just hope that they will work after you’ve taught them once in orientation.”

Dr. Snider described a situation where a Hosparus staff member called in to the office using the protocol taught to staff some years before—with a designated catch phrase to serve as a crisis signal for help. “The people who were supposed to be able to respond just didn’t remember the process,” she said. “So that’s something we learned along the way. Safety and security need to be an essential part of the culture of postacute organizations like hospices. I also think we have to think differently about how we prepare our staff.”

Based on its experience, Hosparus Health has invested more robustly in active aggression training and de-escalation training for the entire organization. According to Dr. Snider, “we brought in experts who had experience with the FBI and in law enforcement for the active aggressor training.” These experts taught Hosparus employees how to respond, what to do, what to look for, and what should be considered red flags. “We have a cycle by which this education occurs at a set frequency to keep it top of mind, and then we do simulations,” she explained. “You have to be prepared at any site for anything to happen.”

“Step two is de-escalation training. We sent staff from our education department to get trained in teaching de-escalation techniques, how to react in those situations, trying to gauge (in a challenging encounter) whether this is grief... [or] anger—figuring out what is driving it and then how we can de-escalate the situation.”

Dr. Snider said the underlying concepts of de-escalation are inherent to hospice clinicians. “It’s about how you listen to people, how you validate emotions. What we had to do is to take the skills they already had, from their experiences [of having] difficult conversations with people, and then help them see how to apply this to the emotions of safety and security when those are under threat.”

The coursework also helps staff better understand the grief and trauma they have experienced in their own lives. “It’s different for everybody, but until you have some awareness of what those triggers look like for you, it’s harder to successfully de-escalate, because you may find yourself in a situation that is a trigger for you,” she said.

> ***THE UNDERLYING CONCEPTS OF DE-ESCALATION ARE INHERENT TO HOSPICE CLINICIANS. “IT’S ABOUT HOW YOU LISTEN TO PEOPLE, HOW YOU VALIDATE EMOTIONS.”***

“The other thing we’re doing is investing in technology that will [help] staff to feel safe and [allow them to] notify someone for help if they should find themselves in difficult situations—not just threatened violence but other kinds of emergencies as well.” Hosparus is preparing to implement a new system, which a few other hospice organizations have adopted, that uses a stand-alone button to silently call for help, with the notification going to EMS or the police to be dispatched to wherever the caller is. These services can also offer 24-hour access for staff as an employee benefit, even when they’re not working, Dr. Snider said. “They’d still have an easy way to call for help when they are in a scary situation.”

A NEW GENERATION OF STAFF

Bluegrass Care Navigators, based in Lexington, KY, is committed to promoting staff safety, says Eugenia Smither, vice president for quality and compliance for the diversified hospice and palliative care agency. “We’re in a place today where a new generation of healthcare workers is coming in without experience of providing care in the home and not comfortable going into patients' homes."

These new employees are not as ready for what can happen in the home, where the patient and family have much more control, Smither said. That is in contrast to experienced hospice staff who sometimes say they've seen everything in their professional work life. The hospice patient's home is inherently a chaotic, dynamic situation because at its center is a dying individual.

"If they're yelling, you lower your voice. If they're challenging you, you try to redirect them. If you are being verbally abused, tell them if that behavior doesn't stop, you're going to leave. You have to trust your judgment when you're out there alone; you know when something doesn't feel right." And all incidents should be reported—including near misses. "We ask clinicians to report information into our system, so we can track how often this is happening," Smither said.

Samuel Weisblatt, MD HMDC, a hospice team physician for VNS Health in Brooklyn, NY, is also involved in his agency's extensive hospice and palliative medicine fellowship training. Roughly fifty fellows from numerous academic programs do rotations annually with VNS Health, which serves New York City, the ultimate urban environment. Fellows are expected to spend a minimum of 4 weeks going on home visits with the hospice team, observing how physician and nonphysician members of the team do their jobs.

"When fellows come to us, by and large, they've never been in a home of someone that they are taking care of. So I start with safety, because that's critical. Of course, we want them to have a wonderful and educational experience, but without safety, there's nothing. Years ago, I worked as a paramedic, and in that job the first thing you do when you arrive on the scene is to check for safety," Dr. Weisblatt said.

"I also think it's critically important to ensure that you have some degree of emotional awareness of your own experience in the home. I haven't encountered violence per se, but in my experience, when things have escalated, it usually starts with a verbal altercation and voices being raised," he said. "Then we have our own emotional response, and our sympathetic nervous system gets activated. But you really need to be able to think critically and tamp that down so that you can lower the heat of the encounter," he said.

> ***"WE'RE IN A PLACE TODAY WHERE A NEW GENERATION OF HEALTHCARE WORKERS IS COMING IN WITHOUT EXPERIENCE OF PROVIDING CARE IN THE HOME AND NOT COMFORTABLE GOING INTO PATIENTS' HOMES."***

"Here we are extensively trained on safety tips, how to navigate spaces," Dr. Weisblatt said. The training is interactive, with case discussions on how to make safe choices, things to look for that suggest you need to be acutely thinking about your safety, listening to your gut. "If we sense that there is a lack of safety, either in the home, or in the elevator or lobby, or even before getting to the building, we're trained in how to navigate that safely, including not making the visit if we're really concerned about our safety."

TREATING ALL ADDRESSES THE SAME

VNS Health does not treat any NYC zip codes as too unsafe to visit and tries to view every address the same. "I can think of two occasions where I was uncomfortable enough with the surroundings that I did not enter a building because I was acutely concerned about my safety," Dr. Weisblatt related. "And in homes, I've had to use that same sense of having to decide: Do I need to leave right now? Is this enough of a safety threat? Was some illegal activity taking place in another room, and was that a direct threat to me? In one such case I was able to finish the visit without concerns for my safety," he said.

"But it led to a multitiered discussion with our team, our manager, and our senior leadership about whether this was a situation where we could no longer continue to provide the care. Ultimately, we were able to provide the care to the person, who died comfortably in their home." That was done by making all subsequent visits jointly, with at least two clinicians present, and everyone who went to that home was offered the availability of a security guard to accompany them.

VNS Health also offers a great deal of staff support such as an employee assistance program, access to mental health professionals, and opportunities to join support groups. "It wouldn't be unusual that one of their expressed concerns would be: 'You know, I visited a home, I was terrified. I'm trying to sort that out.'"

Staff wear agency uniforms, which clearly display its logo, identifying the person as a health care worker. That can be a protective factor in safely entering and exiting some locations, he said. "Our agency does a good job of getting our name out there in the community."

And there is a safety app from **AlertMedia**, an emergency alert notification system, loaded onto agency work phones; when clinicians activate it, the information goes directly to local police. All VNS Health staff can also receive alerts via text, email, and voice messaging, with a template for safety check messages and alerts regarding violent crimes and other civil unrest that impact their service area.

KNOW YOUR COMMUNITY

Michael E. Knower, MD FAAHPM, is a family medicine–trained physician and retired medical director of St. Charles Hospice in Central Oregon. "We're for the most part very rural," he said, and gun ownership is common locally. "One of our newer social workers was told that some patients had firearms in the home, and [they] had a problem with that. This is an area where a one-size-fits-all approach isn't going to work."

> ***FIRST AND FOREMOST...HOSPICE AND PALLIATIVE PROFESSIONALS NEED TO KNOW THEIR COMMUNITY, KNOW THEIR PATIENTS, KNOW THEIR ENVIRONMENT, KNOW THE RISKS.***

First and foremost, Dr. Knower said, hospice and palliative professionals need to know their community, know their patients, know their environment, know the risks. "For example, if you know the person has mental health issues or a proclivity to violence, you need to take steps." In this case, gun ownership was normal for this community. "But when one of our team feels unsafe going into a home, they are not obligated to continue making home visits there." And the agency's administration needs to take staff at their word, he said.

A nurse who was an Army veteran was visiting a patient who was also a vet and who lived 20 miles out of town on property surrounded by six-foot high deer fencing. "When he arrived, the patient said to him, 'I was just now sitting here with my [hunting] rifle. I could see you at my gate through the scope.'" The agency had an interdisciplinary team meeting, and the consensus was to discharge that person because staff did not feel safe—which is one of the recognized criteria for discharge from hospice.

WHAT ELSE CAN HOSPICES DO?

What else can agencies do to protect their staff? To the extent possible, consider limiting visits to daytime hours. Use communication systems to inform the agency's command center when each visit starts and finishes and where and when visiting staff are going next. Let the family know when you're coming so they can look out for you.

Develop closer working relations with local law enforcement agencies. When visiting apartment buildings, try to check in with a desk clerk or security clerk or any other available staff. Have detailed, accurate directions to each patient's home before you leave the office. Make a habit of paying close attention to surroundings, and know where the nearest exits are. Keep your parked car locked and as empty as possible.

Some hospices insist that weapons be secured in the patient's home before staff will come to visit. Others ask screening questions about firearms and a history of violent behavior before visits are made. There are various violence and aggression assessment tools[2,3] that can be used with patients, who can also be asked to sign a "**No Harm & Safe Environment Contract**."

Physical self-defense training (eg, how to extricate yourself from a choke hold) may be helpful in some situations, although we shouldn't expect hospice staff to become fighters. Depending on local ordinances, some hospices might consider permitting staff to carry firearms for self-defense, just like a few EMS services do today[4]—but that is not likely to be a comforting solution for most hospice professionals.

"I think having multifaceted strategies for safety is really important," Dr. Snider said. "It's a real issue that organizations cannot ignore. We need frontline staff to help create part of the solution so we can actually build something that works for them."

> ***"I THINK HAVING MULTIFACETED STRATEGIES FOR SAFETY IS REALLY IMPORTANT...IT'S A REAL ISSUE THAT ORGANIZATIONS CANNOT IGNORE."***

One key to understanding the issues is that hospice teams are invited in to care for people in their homes, which are a big part of what defines them. "I've absolutely been in homes where guns are present and visible. And part of the challenge is that some communities are dangerous for the patient and family, so that gun represents safety and security for them. They don't feel threatened by me," she said. "But it comes down to awareness of those things, right?"

Dr. Snider recommends that hospice and palliative medicine administrators make a point of going on home visits with their staff to see these kinds of situations in person. "And I'm not just talking about one visit. Get in a routine where you regularly experience what it feels like as a care provider to be vulnerable and not in control of a situation in the home when emotions are already high," she said.

Hospice staff "do an extraordinary job across the country in trying to manage really difficult situations with flexibility and creativity and compassion. Where I see organizations fail to meet the needs of their staff is when administrators don't walk alongside them to see what the work really looks and feels like. That's why I still make joint home visits today, even though I'm in an executive position, so I can see the challenges that our staff face." ●

References

1. Lim MC, Jeffree MS, Saupin SS, Giloi N, Lukman KA. Workplace violence in healthcare settings: the risk factors, implications and collaborative preventive measures. *Ann Med Surg (Lond)*. 2022;78:103727. doi:10.1016/j.amsu.2022.103727.
2. Violence Risk Assessment Tools. The National Institute for Occupational Safety and Health. Updated May 16, 2024. Accessed December 19, 2024. https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit6_8.
3. Sammut D, Hallett N, Lees-Deutsch L, Dickens GL. A systematic review of violence risk assessment tools currently used in emergency care settings. *J Emerg Nurs*. 2022;49(3):371-386.
4. Lawrence R. Arming the EMS workforce. EMS 1. Published February 21, 2020. Accessed December 19, 2024. https://www.ems1.com/tactical-ems/articles/arming-the-ems-workforce-vs415d0LXsJDATkW/.

Larry Beresford is a medical journalist in Oakland, CA, with a strong interest in hospice and palliative care.

DEI LAB

THE ROLE OF PALLIATIVE CARE IN CARING FOR PATIENTS WITH SICKLE CELL DISEASE

Arshia Madni, MD FAAP, Rushil V. Patel, MD,
and Jon P. Furuno, PhD FSHEA FAAHPM

Sickle cell disease (SCD) comprises a group of life-limiting, inherited blood disorders characterized by abnormal formation of red blood cells. An estimated 100,000 persons in the US have SCD, of which approximately 90% are Black or African American and 3% to 9% are Hispanic, with smaller numbers of South Asian or Middle Eastern ancestry.[1,2] In this article, we describe a clinical case of a young man with SCD and opportunities for palliative care to improve the patient, family, and provider experience.

Clinical Case

Don is a 20-year-old male with hemoglobin SS SCD admitted to the hospital for pain crisis. He has had many inpatient encounters as a child, including bouts of vaso-occlusive crisis, and has had a history of acute chest syndrome as well. Don and his family have felt the transition to the adult world from pediatrics has not been smooth and are frustrated by the lack of communication with his clinical team. Today he is in his hematologists's office talking about the possibility of gene therapy as a next step. The hematologist wants to discuss this next step and, in the setting of the recent communication stressors, would like to consult palliative care.

DEI LAB

LEARNING • ACHIEVING • BELONGING

Impact of Sickle Cell Disease on Patients and Their Families

Patients with SCD are living longer than before but continue to face the burdens and challenges of those living with a chronic medical condition.[3] Life-threatening symptoms related to vaso-occlusive crisis, hemolysis, and pain can also lead to repeated hospital admissions.[3,4] Along with the physical discomfort, patients face psychological sequalae related to chronic pain and life disruptions including missing work or school.[5]

An additional challenge can be ineffective communication and counseling from providers, leading to suboptimal delivery of essential information around anticipatory guidance, preventive care, and future therapies. Racism, bias, and discrimination embedded in clinical encounters can also lead to miscommunication and poor health outcomes.[5] This can manifest as clinicians viewing patients' expression of pain with skepticism, especially if they do not "look" like they are in pain or have been in the hospital frequently for pain crises.[5,6]

Opportunities for the Palliative Care Clinician

Improving the experience of patients with SCD and their families and addressing inequities in the provision of their care should be institutional priorities. A recent analysis reported that fewer than 1% of patients with SCD admitted to the hospital received a palliative care consultation.[5] Furthermore, several disparities were identified, including that patients who are Black, Hispanic, female, using Medicaid, or receiving care at a rural or urban nonteaching hospital were significantly less likely to be seen by palliative care.[6] Additionally, although hematologists generally find that palliative care is beneficial for patients with SCD, they do not consult as frequently as they would like, especially in end-of-life issues.[7] Stigma and misunderstanding of palliative care services among both patient and providers (hematology and palliative care alike) are potential barriers.

Advocating at your institutions to have palliative care embedded in the care of patients with SCD can help bridge the gap with anticipatory guidance and aid in shared decision making, leading to more equitable and patient-centered care. Palliative care skills that can be utilized include initiating goals-of-care conversations, addressing total pain and suffering, and aiding in shared decisions around advanced therapies (eg, gene therapy).[8]

Return to Don

The palliative care team was able to meet with Don and his family and hear about their experience with sickle cell disease, their hopes, and their worries. They were able to provide Don's hematologist with psychosocial context that allowed them to better connect with Don and build a more trusting relationship. The palliative care team explored Don's thoughts about gene therapy and found that Don and his family's hesitation about gene therapy was related to inadequate information about the risks and benefits as well as feeling unheard. With the ability to build a therapeutic, trusting relationship and feel heard, along with being armed with more information, Don and his family began to feel that gene therapy was in line with their goals. ●

References

1. Kayle M, Blewer AL, Pan W, et al. Birth prevalence of sickle cell disease and county-level social vulnerability—sickle cell data collection program, 11 states, 2016-2020. *MMWR Morb Mortal Wkly Rep*. 2024;73(12):248-254. doi:10.15585/mmwr.mm7312a1.
2. Brousseau DC, Panepinto JA, Nimmer M, Hoffman RG. The number of people with sickle-cell disease in the United States: national and state estimates. *Am J Hematol*. 2010;85(1):77-78.
3. Patel RV, Nwogu-Onyemkpa E, Kanter J, Osunkwo I. Palliative care for adults with sickle cell disease: an unrecognized opportunity. *The Hematologist*. 2024;21(5).
4. Sickle Cell Disease. American Society of Hematology. Accessed October 18, 2024. https://www.hematology.org/education/patients/anemia/sickle-cell-disease
5. Aurora T, Bridges C, Porter A, Madni A. Pediatric sickle cell disease: a case for improved clinician–family partnerships. *J Hosp Med*. 2024;19(2):146-148.
6. Nwogu-Onyemkpa E, Dongarwar D, Salihu HM, et al. Inpatient palliative care use by patients with sickle cell disease: a retrospective cross-sectional study. *BMJ Open*. 2022;12(18):e057361. doi:10.1136/bmjopen-2021-057361.
7. Nwogu-Onyemkpa E, Saleem N, Amspoker A. Sickle cell disease providers' perspectives on palliative care. *J Pain Symptom Manage*. 2024;67(5):e539-e540.
8. Patel RV, Johnston EE. End-of-life care for people with sickle cell disease: barriers to and facilitators of high-quality care. *Hematology Am Soc Hematol Educ Program*. 2024;2024(1):355-362.

Arshia Madni, MD FAAP, is an assistant professor of pediatrics and associate program director of the hospice and palliative medicine fellowship at the University of Tennessee Health Sciences Center/Le Bonheur Children's Hospital. She also is chair of AAHPM's DEI Committee.

Rushil V. Patel, MD, is an assistant professor of medicine in the division of hematology and oncology and the division of geriatrics, gerontology, and palliative medicine at the O'Neal Comprehensive Cancer Center at The University of Alabama at Birmingham.

Jon P. Furuno, PhD FSHEA FAAHPM, is a professor in the department of pharmacy practice at Oregon State University College of Pharmacy.

Support Professional Development

Hospice Super Forum

100+ **ATTENDEES WHO PARTICIPATED IN THE INAUGURAL HOSPICE SUPER FORUM ON NOV. 14, 2024**

This AAHPM and Hospice Medical Director Certification Board (HMDCB) half-day virtual event featured updates on hospice ethical challenges, hospice deprescribing, and managing complex symptoms. Gratitude to faculty members Mary Lynn McPherson, PharmD PhD FAAHPM, Mina Chang, MD HMDC FAAHPM, and David Wensel, DO HMDC FAAHPM.

A recording of the Hospice Super Forum with accredited CME will be available for purchase soon.

Grand Rounds

AAHPM hosted its Fall Quarterly Grand Rounds on November 7, entitled If Me, Then You: Attaining Leadership Through Growth Opportunities, with Joanne Wolfe, MD MPH FAAHPM, serving as Grand Rounds Lecturer. Dr. Wolfe shared her journey of leadership, focusing on the importance of seizing opportunities and fostering personal growth. The recording of this outstanding lecture will be made available in the first quarter of 2025.

AAHPM CME Mission Statement

AAHPM's Education and Learning Strategic Coordinating Committee chaired by Christine Kandehwal, DO MHPE HMDC FAAHPM, updated the AAHPM CME Mission Statement to align with the Academy's 2024-2027 Strategic Plan.

CME Mission Statement

The American Academy of Hospice and Palliative Medicine strives to contribute to our members' success and professional growth as educators, researchers, clinicians, and administrators through the provision of valid and independent educational content that supports improvements to strategies, skills, performance, and coordination as healthcare teams.

Educational content is designed to change competence and/or practice and prepare the workforce for changes in care delivery, develop a new cadre of physician and interprofessional leaders for hospice and palliative care, achieve advocacy priorities that advance and sustain the field, and support the professional development and well-being of a diverse and inclusive workforce across settings of care needed to meet increasing demand. AAHPM promotes professional development that supports the organization's vision, mission, and values.

QUARTERLY PROGRESS REPORT

AAHPM POINTS OF PROGRESS

Advocacy Update

8 AAHPM MEMBERS WHO ATTENDED THE AMA HOUSE OF DELEGATES INTERIM MEETING NOV. 8-12, 2024, IN FL

3 AAHPM MEMBER DELEGATES TO THE AMA

1 AAHPM PRESIDENT

4 AAHPM MEMBERS SERVING AS DELEGATES OF OTHER ORGS

AAHPM's AMA Delegation of Chad Kollas, MD FACP FAAHPM, Ruth Thomson, DO MBA FAAHPM, and Ana Leech, MD FAAHPM, represented the Academy at the American Medical Association (AMA) House of Delegates Interim Meeting in Orlando, FL. AAHPM President Vicki Jackson, MD MPH FAAHPM, also participated, as did AAHPM members who formally serve as delegates of other organizations including Holly Yang, MD MACP FAAHPM, Kyle Edmonds, MD FAAHPM, Toluwalase Ajayi, FAAP FAAHPM, and Karl Steinberg, MD CMD.

AAHPM was successful in garnering passage of the following:

- **Expanding Palliative Care**, a Board of Trustees report recognizing palliative care as a human right and providing a comprehensive definition
- **Expanding Access to Palliative Care**, a Council on Ethical and Judicial Affairs report amending the Code of Medical Ethics to include an opinion on palliative care.

The passage of these reports recognizes the value of palliative care by the AMA and provides a starting point for additional advocacy in order to increase access to necessary services.

AAHPM sent an Action Alert to all members regarding extending current telehealth flexibilities. These flexibilities allow for expanded access to telehealth and were set to expire at the end of 2024. See the Advocacy Update in this issue for more details.

900 MESSAGES SENT TO CONGRESS IN RESPONSE TO THE ACTION ALERT

Support a Vibrant Community

Workforce Group Update

AAHPM is proud to be hosting a bimonthly program director and associate program director mentor meeting to discuss various themes to support fellowship programs throughout the academic cycle. There is also a Connect page dedicated to program and associate program directors. If you would like to be added to either of these, please reach out to Laura Witt at lwitt@aahpm.org.

Ensure a Strong Organization

aahpm learn

The Leadership and Career Development Committee is developing micro-learning, on-demand education as part of AAHPM's Learn library. These quick 15- to 20-minute videos include Introduction to the Business Side of Palliative Medicine, Inclusive Leadership, and Portfolio Management.

The Fellowship Training Committee implemented the best practices repository that was hosted on Connect for program directors and associate program directors to generate ideas, see other people's work, and contact programs to learn about their best practices

HOSPICE MEDICAL DIRECTOR
CERTIFICATION BOARD

AAHPM PARTNER UPDATE

HMDCB UPDATE

Become Certified in 2025

The 2025 initial application is now open! Highlight your knowledge as a hospice physician and join the HMDCB community by becoming HMDCB-certified this year. Prepare now by reviewing the eligibility requirements and exam prep resources available at www.HMDCB.org/exam.

Renew Your HMDC Credential

If your HMDC credential expires in 2025, make sure to renew by October 31, 2025. The Continuing Certification Program includes a longitudinal assessment that is open book, is untimed, and can be retaken as needed to help assess and expand your hospice knowledge. By renewing your credential, you can continue to highlight your expertise in hospice medicine and enjoy HMDCB community benefits, including webinars, coffee chats, and discounts on CME opportunities! To learn more about the renewal process, visit www.HMDCB.org/ccp.

Advertise with HMDCB

HMDCB invites hospice employers to promote their organization, educational activities, and jobs to more than 1,300 dedicated hospice physicians and medical directors through its advertisement program. Visit www.HMDCB.org/advertising to learn more.

A Message of Gratitude

HMDCB is grateful for the hospice and palliative medicine community. Thank you for everything you do to care for patients, families, and your communities. Your impact is immeasurable, and HMDCB is incredibly thankful.

HMDCB is also thankful for its remarkable board of directors and committee members. These volunteers help advance HMDCB and the hospice field. Below is a quick look back at some of the highlights HMDCB experienced in 2024.

January 2024: Launched the new Continuing Certification Program

March 2024: Received an AAHPM Presidential Citation at the Annual Assembly

June 2024: Connected with several external partners to discuss new initiatives to better support the hospice field

September 2024: Certified 127 new hospice physicians

November 2024: Cohosted the inaugural Hospice Super Forum with AAHPM

Thank you to everyone who helped make these accomplishments possible.

Contact HMDCB

HMDCB staff are happy to answer your questions or assist you. Contact HMDCB staff at info@hmdcb.org or call 847.375.6740. ●

AAHPM NEWS

MEET THE NEW AAHPM CMO: KRISTINA NEWPORT, MD HMDC FAAHPM

How did you choose to pursue the specialty of hospice and palliative medicine?

During medical training, I found myself gravitating toward people whose suffering was unaddressed. The people I saw providing the care that truly focused on what was right for those patients were the hospice and palliative care (HPC) clinicians. After learning about the burgeoning specialty, I had no doubt that HPC was the perfect path for me to work as part of a team to help people live as well as possible, regardless of their illness or personal situation.

Which aspects of providing hospice and palliative care do you find most rewarding?

The most rewarding part of HPC is working with an interdisciplinary team to help make terrible situations a little less terrible. No matter what challenges we encounter, someone on the team has the ability to help people feel seen and heard and address their needs.

What part of the CMO role excites you the most?

I look forward to meeting members and hearing about the unique work they are doing as well as the challenges they face so I can be a part of relevant, evidence-based, collaborative efforts to improve the way we equitably provide serious illness care in this country.

What can be done to help others—physicians and medical professionals, patients and family, lawmakers, and the media—become more aware of hospice and palliative care?

There are many layers to delivering the message about hospice and palliative care. It starts with personalized care for every patient we meet so their good experience is an example for their family and friends. Next, we should all consider ourselves teachers, whether working in academics or not, since we have daily opportunities to share stories with our colleagues, community leaders, and political representatives about the way hospice and palliative care can help people live well. When public figures disclose serious illness, we should take the opportunity to help the public understand their illness and their care choices. Lastly, we should intensify our collaboration with other professional organizations and research entities, ensuring the infusion of palliative care principles into care pathways and research priorities.

When you have free moments outside of your work, where can we find you?

Most of my free time is spent with my family: my husband, 14-year-old daughter, and 16-year-old son. My husband and I enjoy attending their school and sporting events as well as travelling and hiking with them. When they are practicing pole vaulting and volleyball, I can be found gardening, reading, running, and enjoying lattes at the local coffee shop with my neighbors.

Tell us about those who have most influenced your work path?

My parents influenced me from the very start: my father taught me that hard work always pays off and my mother taught me there is always something we can do to help others. My residency program director, Ted Bollard, instilled a high standard of medical care and a belief in myself and my colleagues that we have the ability to change medicine for the better. Tom Smith and Pat Coyne led by example in always figuring out a way to help people live well in the face of cancer and other life challenges during my fellowship. Joan Harrold, along with the staff at Hospice & Community Care, "raised me" as a hospice physician, and my team members at Penn State Health teach me every day how to meet people where they are and ensure they feel seen and heard. Lastly, my valued colleague and friend Shanthi Sivendran challenges me daily to consider how to improve the care we provide and eliminate disparities in cancer care and palliative care in general.

What else would you like AAHPM members to know about you?

The work that we all do is hard, and we will always face challenges in doing it well. But together we can continue to improve the lives of those around us and provide patient-centered care to all who need it. ●

Education

- MD, Penn State College of Medicine
- BS, Speech Pathology, Kutztown University of Pennsylvania

Specialties

Hospice and palliative medicine

Years in Hospice and Palliative Medicine

17

Current Affiliations

Penn State Health

AAHPM Activities

- 2024 Chief Special Interest Group Chair
- 2021 Reviewer, Fellowship Applications
- 2020 Reviewer, Annual Assembly Abstracts
- 2020 Reviewer, Emerging Leaders Applications
- 2019 Cancer Special Interest Group Chair

Honors and Awards

- 2021 Penn State Health Department of Medicine Exceptional Performance Award
- 2018 American Academy of Hospice and Palliative Medicine Hearst Leadership Scholar
- 2017 American Cancer Society, East Central Division's Excellence in Mission Award
- 2016 Kutztown University of Pennsylvania Athletic Hall of Fame Inductee
- 2016 Pennsylvania Medical Society's Physician 40 Under 40 Award
- 2015 Fellow of the American Academy of Hospice and Palliative Medicine
- 2015 American Academy of Hospice and Palliative Medicine 40 Inspiring Leaders Under 40

MEET A SCHOLARSHIP RECIPIENT: LINGSHENG LI, MD

In 2024, Lingsheng Li, MD, received a scholarship as part of the Research Scholars Program and attended the Annual Kathleen M. Foley Palliative Care Retreat and Research Symposium from September 25 to 27 at Cliff House in Maine. Dr. Li shared an illustrated reflection of her experience at the retreat.

Cliff House

Sept 25-27, 2024
17th Annual Kathleen M. Foley
Palliative Care Retreat &
Research Symposium

Drawn journaling by
Lingsheng Li, MD MHS
(AAHPM research scholar '24)

There were so many reasons why I cherished every moment of this year's Foley Retreat at Ogunquit, a storybook-like town in Maine.

Here are my top 10 reasons:
(in no particular order of importance)

① The people

- senior & peer mentors
- researchers who share similar vision & mission & goals
- Current & former research scholars
- Kat, Lily, & Jennifer!

② the inspiring speeches on leaving a legacy, pursuit of better decisions, the impact of loneliness & isolation, & the journey from bedside to research to policy.

③ Interesting mealtime conversations with a diverse range of topics, from biopsychosocial spiritual models of care to mushroom foraging.

④ waking up & falling asleep to the sound of ocean waves.

⑤ listening to the poster presentations & feeling incredibly energized.

⑥ Discussions on integrating the principles of palliative care into surgical practice.

⑦ rainy day hikes & lobster paintings

⑧ Learning about how NOT to respond to grant proposal comments (while eating chocolate)

⑨ Fresh lobster rolls with warm butter

⑩ the gift of community.

AAHPM NEWS

MEET THE 2024-2026 NEXT GEN SCHOLARS COHORT

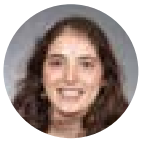
Join us in celebrating the second cohort of scholars and sponsors for the AAHPM Next Gen Scholars for Equity in Hospice and Palliative Medicine program. This program sponsors postgraduate medical residents interested in hospice and palliative medicine from communities that are underrepresented in the profession's workforce and leadership and who will be essential as our professional community works together toward centering the needs of those currently marginalized in hospice and palliative medicine.

2024-2026 Scholars

Alexander Evans Ayala, MD MPH

Alameda Health System

Emergency Medicine, PGY-4



Yasmina Hachem, MD

Mount Auburn Hospital

Internal Medicine, PGY-3

Kimberly Mendoza, MD PhD MPH

University of Colorado

Anesthesiology, PGY-4

Tochi Jeffrey Nwaneri Nwosu, MD

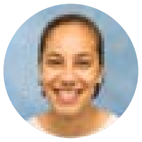
Alameda Health System

Internal Medicine, PGY-4

Sheila Okere, MD

Mayo Clinic Florida

Internal Medicine, PGY-3



Daniella Ortiz, MD

University of North Carolina

Family Medicine, PGY-3

Helen Toyer Queenan, MD

University of Colorado

Internal Medicine–Pediatrics, PGY-3

Ciara G. Smith, MD

University of Kentucky

Internal Medicine–Psychiatry, PGY-4

Thank you to the HPM leaders serving as sponsors for the scholars.

Julie Childers, MD FASAM FAAHPM

Heather A. Harris, MD FAAHPM

Kimberly Kopecky, MD MSCI

Dana Lustbader, MD FCCM FAAHPM

Sonia Malhotra, MD MS FAAP FAAHPM

VJ Periyakoil, MD FAGS FAAHPM

Tammie E. Quest, MD FAAHPM

Holly Yang, MD HMDC FACP FAAHPM

For more information, visit aahpm.org/scholarship/next-gen-scholars.

ARTIST IN RESIDENCE

HEATHER MIKES, DO FAAHPM

Katie Mechler, MD

Affiliation
UPMC

Years in Hospice and Palliative Medicine
12

Medium
Mosaics

Artist Q&A

How did you get started with your art, and describe if it has changed over your hospice and palliative care career?

One day in college I was in Barnes and Noble bookstore, and I happened to see a book on mosaicking—I'm not sure why I found it, but I saw it and thought that it looked like fun. The Home Depot was in the same shopping center, so I just went and bought the materials and started the next day! I found it so enjoyable, deep, and spiritual. There's something so cathartic about smashing tile into lots of different pieces and bringing it back together to form something completely different. Through the years the main change is the tools I use. Now I sometimes use a wet saw to get precise cuts but, let me tell you, there's nothing better than hitting tiles with a hammer—divine stress relief! I've grown in confidence and made bigger pieces. The time I have to create is now shorter, as I put my creative energy into my garden in the spring and summer, but I return to mosaics every year in the late summer and fall.

What is your creative process?

I have a tiny studio in my basement where I keep interesting tiles that I collect over time. When I have an idea, I can go there and pick the right color palate from my many tiles. I find my ideas from nature: my garden, places I've been, and places I want to go. I'll pencil a rough design onto the wood back but then it's time to smash the tiles and lay out the rough pieces. This is the best part. It's like a jigsaw puzzle, looking closely at the shards and finding the pieces that just fit. Sometimes you have to get out the hammer and smash it again to make it fit. Then I step back and try to get some perspective, look at the big picture, visualize it as a cohesive piece. Next, I glue the pieces in place and take it outside to mix and apply the grout. Grouting is a process of patience: cover the piece in grout, then wipe it off with a sponge when it's dry enough but not too set. The final step is hand painting sealant to all the grout. It's fully ready 24 hours later.

Describe your art in seven words or less.

Broken and restored in a new way.

What do you want people to take away from your art?

I create mainly landscapes, including one of Mount Hood, which is near where I did my palliative fellowship. If people look at my mosaics, I hope they get a sense of joy and inspiration. If that's what they get, I am happy with that.

What are future plans for your art?

I would love to go to Barcelona because I'm inspired by Gaudí and all mosaics he did. Until then I will work on my humble pieces. I'm planning to create the Giant's Causeway with some nice, layered glass tiles, and then I'm making another waterfall piece, which will be like a cascade of tiny blue tiles.

How do you deal with perfectionism and the inner critic in your art?

Well, I have to remind myself that all of my pieces are broken and intentionally irregular at times. And I tell myself that grout covers up a lot of imperfections. Mosaic making as an art is more forgiving at times—until the grout hardens at least. I feel like once the grout dries, then comes a wave of acceptance. This is art, a journey!

What advice do you have for your younger self, or what do you want our readers to know?

I would definitely tell myself, "Remember not to let the grout dry all the way before you start wiping it off!" Grout is hard to remove from tile once it's fully set. It really is an exciting moment when the extra grout is wiped away and your piece is revealed for the first time. For anyone who has ever thought about mosaicking: it's so easy, you should try it! You can start with a kit so that you don't have to worry about making a big mess. Otherwise, the supplies you need are a piece of wood, strong glue, tile, and a smashing device of your choice. I advise wearing safety goggles and gloves, too. Mosaicking is just so much fun and each piece is one of a kind. The satisfaction you'll get from planning and creating it will fill your soul! ●

This interview has been edited.

CALLING ALL AAHPM MEMBER ARTISTS: PAINTERS, PHOTOGRAPHERS, SCULPTORS, POTTERS, QUILTERS, DIGITAL ARTISTS, CARTOONISTS, EVEN DOODLERS—CASUAL OR SERIOUS CREATORS OF ANY KIND!

Artist in Residence is a new column that seeks to highlight AAHPM members who create art as part of their professional or private lives and wish to share said art with the AAHPM community to encourage connection and healing. Email info@aahpm.org if you would like to be considered for the next Artist in Residence.